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ASSESSMENT OF EPSDT PRACTICES AND COSTS

FINAL REPORT

August 20, 1976

Office of Planning, Research, and Evaluation
Social and Rehabilitation Service
Department of Health, Education, and Welfare

Contract No. SRS-500-75-0019

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SECTION I: INTRODUCTION

The Assessment of EPSDT Practices and Costs was conducted in three phases, each related to one of three major concerns delineated in the RFP. The first phase was an assessment of barriers to full implementation of the EPSDT program; the second, an assessment of best practice methodologies for screening and case management activities; and the third, an assessment of the impact of EPSDT on State Medicaid budgets.

For the first phase, interviews to determine and assess barriers were conducted with State Medicaid officials in six States. A Barrier Assessment Questionnaire was developed and utilized for these interviews. States were chosen for participation on the basis of five criteria: (1) availability of cost data and information on best practices and barriers; (2) approach to screening activities used by the State (i.e., provider type - private providers, health departments, or a combination of the two); (3) existence of significant EPSDT costs and eligible population; (4) geographic location of the State; and (5) willingness to participate in the study.

The second phase required detailed interviews with local screening providers at three locations in each of the six States to gather information on screening and case management methodologies. OMB approval (Form no. 83 S 75000) was obtained for a Best Practices Interview Guide to conduct these 18 on-site interviews. Participating States chose three local sites for interviews which represented the best local programs in the State. These sites were to be able to supply detailed local data and information sufficient to complete our analysis of screening and follow-up. Reputed cost-effective performance of screening and case management was a secondary criterion for site selection.

The third phase assessed the impact of four cost components on Medicaid expenditures in two participating States. Availability of cost data and willingness to participate in the cost assessment were criteria used to select the two States. Cost components were State-level administrative costs of EPSDT, local level administrative and operational costs of EPSDT incurred by screening providers and social service agencies, and medical service expenditures incurred by Medicaid on behalf of EPSDT participants. Cost data were gathered in interviews with State Medicaid officials in two participating States, and interviews with local social service and screening providers at two sites in each State. Medical services utilization and expenditure data were obtained by sampling Medicaid paid claims files to obtain records for 800 screened and 800 unscreened Medicaid eligible children in each of the two States.

SECTION II: MAJOR FINDINGS AND CONCLUSIONS

BARRIER ASSESSMENT

In September and October of 1975, State Medicaid officials in six States were interviewed to assess barriers to full implementation of EPSDT. Objectives were to identify major barriers in each State, evaluate the significance of their impact, and make recommendations for overcoming them. Major barriers identified in this phase are presented below followed by recommendations for resolution of each.

Inadequate Notification

Although eligibles are notified of the EPSDT program at least once per year, the notification process was found to be minimal or confusing to the eligible population in the majority of States. This caused many potential participants to express "no interest" in the program and to refuse screening. In addition, the notification process was frequently utilized to determine the eligible's need for screening without the employment of relevant criteria.

- Written notification should explain EPSDT in easily understood language with an attractive format, creating a strong link between screening and treatment (if required).
- Oral notification should be performed by trained, indigenous personnel at the time of outreach.

Inadequate Outreach

Although most State officials agreed that outreach is potentially the most effective way to increase participation in the program, personal visit outreach is usually not provided to the majority of the eligible population. If this type of outreach is provided, it is done in a limited manner, or it is not specifically directed toward health care and the EPSDT program.

- Some type of EPSDT outreach, preferably home visits, should be done by all screening providers, and where applicable or relevant, by local social service agencies.
- Personal visit outreach should provide a full explanation of the EPSDT program within a health oriented setting.

Lack of Commitment by State Legislatures and State and Local Departments of Social Services and/or Health

Regardless of the fact that all of the States in the study had implemented the EPSDT program at least one year prior to the site visit, and that two of the States had done so as early as 1971, the officials and the agencies they represented did not show that they had committed enough of their personnel to EPSDT program planning, management and technical assistance.

- State agencies should develop an annual program plan that defines specific goals, plans for implementing these goals, and reviews of performance.
- Regional/State conferences on EPSDT should be held to acquaint the States with what other States are doing to implement and improve the program.
- As much initiative as possible should be returned to the States to target and coordinate their resources according to each State's ability.

Inadequate Funding, Limited Allocation of Funds, Inefficient Utilization of Funds

Funding has been a major barrier for the EPSDT program since its inception. It was found that the lack of funding by State and county governments is still a major barrier to full implementation of the program. Although Medicaid expenditures account for a significant portion of every State's budget, the amount allocated to the EPSDT program is very small. Those funds that were allocated to the State agency for provision of EPSDT services were not always utilized efficiently.

- Financial incentives should be given States to increase their present screening rate to an optimal level.

- State agencies with limited funding should attempt to concentrate expenditures on those eligibles with the greatest need for EPSDT and on the completion of critical referrals.
- A sliding-scale incentive system should be implemented whereby additional funds, up to one percent of AFDC funding, are made available to those states that administer the program efficiently and effectively.

Lack of Provider Commitment, Lack of Providers

Private physicians, clinics, and hospitals were generally not interested in providing EPSDT screening services to the eligible population, even though they provide the majority of diagnosis and treatment services. In addition, the actual number of active screening providers, public and private, is rather small: approximately one provider for every 3,000 eligible children. Public health providers, when in an autonomous local health department system, have also been reluctant to commit themselves to the EPSDT program. Shortages of dentists, ophthalmologists and pediatricians have affected the diagnosis and treatment portions of the EPSDT program.

- State agencies should use well thought-out recruiting measures to attract additional, active screening providers, namely physicians and comprehensive care providers.
- State officials should be aware of, and responsive to, the difficulties that providers encounter with the Medicaid program.
- State officials should involve the State medical society, medical schools, health associations, etc., in the planning and operation of the EPSDT program wherever possible.

Inadequate Health Education and Training

It was found that many members of State legislatures and program staff had little knowledge of preventive medical care, comprehensive health care, or health care planning. In addition, little effort was underway to educate the eligible population about preventive health care or the optimal utilization of existing health care programs.

- State agencies, which are responsible for the program but which are not health oriented, should receive specific health related (EPSDT) technical assistance.
- State agencies should provide information about the EPSDT program to health educators or others within each local public school system.

Recipient Apathy and Lack of Understanding

Statistics from three States conducting studies on recipient participation showed that as much as 70 percent of the eligible population notified of the EPSDT program expressed no interest in the program or its benefits. In addition, as many as half of the eligibles scheduled for screening failed to keep their appointments and as many as one quarter refused follow-up treatment. In these States, as well as in the other States, some of the eligible population perceived episodic or crisis medical care as adequate or all-encompassing.

- Notification, outreach, and scheduling of the appointment should occur at the same time with some choice of time and date available to the recipient.
- Screening providers should create a strong personal relationship with the recipients by offering counseling and maintaining individual medical records on all recipients.
- Follow-up on "no-shows" for screening and treatment should take place at the local level, by phone or personal visit, and should occur within one or two weeks of the broken appointment.

Lack of Coordination Between Agencies and/or Providers

Given the range of services required to successfully implement the EPSDT program, coordination within State agencies and between various agencies and providers offering health care or related services should occur on a timely basis. In the majority of States, however, very little coordination existed within State agencies, or between agencies and health care programs, such as school health programs. These programs have strongly resisted any efforts to coordinate their activities with the EPSDT program.

- State agencies should take the initiative to open channels of communication with other agencies and local providers of EPSDT services. Suggestions should be implemented whenever feasible and relevant.
- Compromises should be worked out in the program so that the program can be integrated into the current, on-going pediatric and school health programs.
- Screening providers should become integrated with treatment providers whenever possible and over a suitable time frame.

Fragmentation of Services

The amendment to the Social Security Act that created the EPSDT program clearly emphasizes that the eligible population should have access to a coordinated, integrated evaluation process and health care system. None of the States surveyed had developed or was utilizing a fully coordinated system of comprehensive care services. Providers who could supply integrated services in part, such as HMOs, pediatricians, family/general practitioners, primary care group practices, clinics and organized outpatient departments within hospitals accounted for less than 10 percent of the screenings performed. More importantly, none of the States surveyed had emphasized the provision of screening, diagnosis, and treatment in a comprehensive care setting.

- Financial incentives should be offered comprehensive care providers to actively participate in screening.
- States should utilize the public health system wherever possible, but not to the exclusion of other types of providers, or where their capabilities for provision of treatment are extremely limited or non-existent.
- Screening providers should be required to develop an integrated medical record for each child who is referred and transfer this record or part of it to the treatment provider upon referral.

Inadequate Management Information System

With the inception of the EPSDT, information systems have been developed to generate data required by the Federal Guidelines

on EPSDT. However, these systems have not provided the data necessary for analyzing the effectiveness of the entire program or for making management decisions related to program efficiency. State EPSDT administrators have no definitive way of determining the impact of a particular component of the program. Information concerning the relationship between screening and the treatment related to that screening is non-existent.

- Orient the information system towards management analysis and evaluation of the EPSDT program rather than toward the present recording or documentation of screening services.
- Create a comprehensive information system that tracks the eligible recipient through the EPSDT cycle: from screening through treatment (if necessary) and back again to periodic rescreening.

BEST PRACTICES ASSESSMENT

In January and February of 1976, 18 sites in six States were visited to assess EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) screening and case management practices. The primary objectives of the assessment were (1) to determine whether screening and case management methods affected types of conditions uncovered, validity of findings, cost, capacity of the system, rates of treatment completion, and subsequent participation of recipients in comprehensive care programs, and (2) to find the most efficient and effective approaches to screening and case management. The assessment yielded the following major conclusions:

- The types of conditions uncovered and the validity of the screening findings did not appear to be related to any particular method of screening.
- The method of screening did have an impact on the cost per screen and the capacity of the screening system.
- The types of conditions treated, and subsequent participation of the eligible population in comprehensive care programs, did not appear to be related to a particular case management approach.

- The method of case management utilized did have an impact on the rate of treatment completion and the cost of case management activities.
- The "best practice" to provide EPSDT screening and case management services would --
 - Have the local provider furnish a broad range of health services including, but not limited to, outreach, screening, and case management.
 - Have the State Medicaid Agency generate a monthly printout of Medicaid eligibles under 21 years of age with addresses and date of last screening; the printout would be sent to the provider via the local social service agency every month.
 - Have the local screening provider also perform outreach with a systematic plan to reach the entire local eligible population under 21 years over a three-year cycle. Outreach would comprise notification, explanation, confirmation of interest, scheduling of screening appointments (allowing for a historical no-show rate of about twenty to twenty-five percent), scheduling of transportation, and the completion of health history and immunization status. Full-time, nonprofessional, indigenous workers would perform the actual outreach with each worker servicing an eligible population of 5,000 to 8,000 children.
 - Have the local provider schedule screening sessions at varied hours each week (both mornings and afternoons and at least one evening or weekend time period) with twelve to fourteen screenings per session (three to four screenings per hour). Eligibles would have some choice of time and day.
 - Have the local provider utilize a core package of test procedures consisting of vital signs, growth assessment, vision, hearing, dental inspection, hematocrit, urinalysis, nutritional assessment, developmental assessment, unclothed physical exam, health history, and immunization status with the use of optional tests according to age, race, sex, and geographic location. Health aides would perform all the tests, except the physical exam, the evaluation of findings, counseling, and education of the client, which would be done by the nurse practitioner. Periodicity, test procedures, thresholds, and equipment would be identical to that prescribed

in A Guide to Screening.^{1/} Direct supervision, professional consultation, written policy and procedure manuals, and retesting of positives on a selected basis would be utilized to maintain quality control. Three attempts would be made to reschedule no-shows.

- Have the local screening provider, not the local social service agency, perform case management activities, comprised of scheduling the referral appointment, scheduling of transportation, confirmation of the referral-appointment, establishing follow-up and feedback on the results of the referral appointments, and follow-up on the referral no-shows. (The outreach worker from the screening provider would do case management as well as outreach.)
- Have the local provider staff outreach, screening, and case management activities as a whole, with a team consisting of two outreach workers, one clerk/secretary, two health aides, one nurse practitioner, and physician consultant. The total direct labor cost for all screening activities should range between \$16.00 and \$19.00 per child screened.
- Have the local provider develop an orientation program for new staff, conduct inservice programs, prepare procedure manuals, and hold staff meetings for all personnel, with a specific, carefully structured, and thorough OJT program for all non-professional staff.
- Have the local provider maintain a "problem-oriented" medical record on-site for each child screened, containing a health history and immunization status, test results, examination findings, evaluation results, referral form, and referral appointment results. In addition, the provider should maintain a "tickler" file for referral appointments and assemble a bi-monthly management report containing major indices of performance.
- Have the local provider establish a network for rapid and efficient data flow. Included in the network would be the State Medicaid Agency, the local social service agency, the local screening

^{1/}U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, A Guide To Screening for the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) under Medicaid, (SRS) 75-24516.

provider, and the local providers of diagnosis and treatment services.

- The entire best practices system configuration can be implemented in any State in relatively short time span of two to three years. Individual components can be adopted in three to six months. The most difficult problem will come in the development of variations to suit local needs, particularly in the areas of provider coordination, information systems, and manpower utilization. A difficult choice for implementation will have to be made between "cost effective" and "best practice" methodologies wherever the two differ.
- The best practices system configuration delineates an optimal set of resources for screening and case management. Once implemented, the system configuration will require continuous re-evaluation to determine its long run appropriateness. It will be necessary to evaluate the best practice system over time to determine its real value.

COST IMPACT ASSESSMENT

In April and May of 1976, two States were visited to assess the impact of EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) Program on Medicaid expenditures. The primary objectives of this study were (1) to determine the impact of the EPSDT program on (a) the cost and (b) the utilization of medical services by type and location of service, (2) to measure EPSDT administrative costs at the state and local levels, and (3) to determine the extent to which the EPSDT program has modified short-run total Medicaid child health care expenditures for a one-year period in two states. The following major findings and conclusions resulted from the study (caution should be used in generalizing these findings to other States).

Impact of EPSDT on Utilization of Medical Services under Medicaid

- After adjustments were made to the raw data to account for the effects of screening itself on reported utilization of services, utilization differences were found to exist between screened (EPSDT) and unscreened (non-EPSDT) members of each State's Medicaid eligible population.
- In both States, screened persons used fewer physician office visits, fewer pharmaceutical prescriptions, and fewer inpatient hospital days than did unscreened persons. In both States, screened persons used more dental procedures, more clinic visits, and more clinical service visits than did unscreened persons.
- In several medical service categories, screened persons were higher utilizers in one State and lower utilizers in the other State in comparison with unscreened individuals in the same State. These medical service areas were outpatient hospital visits, physician other visits, physician emergency visits, and other service units (i.e., podiatrist, independent laboratory, ambulance, etc.)
- Utilization differences between screened and unscreened members of the samples in both states were attributed to EPSDT. Most notable among these differences was the tendency of screened persons to use fewer inpatient hospital days and physician office services and more dental and optical services than their unscreened counterparts in the Medicaid population.

Impact of EPSDT on Expenditures for Medical Services under Medicaid

- Expenditure differences were found between screened and unscreened members of the eligible population in each State.
- Expenditure differences between screened and unscreened eligibles followed the same pattern as utilization differences with the exception of one service category (physician office visits) in State 1.

- In both States, expenditures for screened persons were lower for pharmaceutical prescriptions and inpatient hospital days than for unscreened persons. In both States, expenditures for dental procedures, clinic visits, and optical services were higher for screened than for unscreened persons.
- In several medical service categories, screened persons had higher expenditures in one State and lower expenditures in another State in comparison with unscreened persons in the same state. These medical service categories were physician office visits, outpatient hospital visits, physician other visits, physician emergency visits, and other service units.
- In aggregate, it was found that EPSDT decreased Medicaid medical service costs only in State 2. Medical services costs in State were reduced \$46,885 for the sample population. In State 1, EPSDT increased medical services costs \$9,096 for the sample population. On average, screened persons expended \$195.22 in State 2, while unscreened persons expended \$253.83. In State 1, screened persons had average expenses of \$155.70; unscreened persons had average expenses of \$144.33.

Impact of EPSDT on Local Administrative and Operational Costs

- It was found that the cost per screening exceeded the Medicaid reimbursement rate at all four local sites. Local costs were \$43.84 at one site and \$142.14 per screening at the other site in State 1, where Medicaid reimbursed local providers \$12.00. In State 2, cost per screening was \$186.83 per screening at one site and \$342.25 at the other site, whereas average reimbursement from Medicaid was \$23.00 per screening.
- Screening providers incurred costs primarily in the areas of screening (at least 50 percent of total provider costs for each of the providers) and administration/overhead, while cooperating social service agencies at each site had all of their costs tied up in case finding and case follow-up activities. The screening providers themselves accounted for 59 percent or more of all local costs in two of the four sites. The social service agencies accounted for the bulk of costs of the other sites.

- EPSDT activity costs (case finding, screening, case follow-up, and administration) varied considerably among providers and to some extent among local social service agencies. Although a definite explanation for the cost variations in screening or in the other activities was not obvious, it appeared that the providers and agencies that had comparatively high unit costs chose to have a larger staff or a staff with higher skill levels than those with lower unit costs.
- Using provider cost data available from another State as a comparison, only two of the four providers we visited had costs reasonably similar to the modest levels typical of local providers in the comparison State. Consequently, generalization of the observed cost data to other States or to other sites in the study States should be done with caution.

Impact of EPSDT on State Administrative Costs

- The findings indicate that the EPSDT Program increased State administrative costs for Medicaid \$102,386 in State 1 and \$213,455 in State 2.
- The analysis of the findings shows (1) that the impact of the EPSDT Program on State administrative costs in each of the two States was very small in comparison to local site EPSDT costs, (2) that the differences between the two States in administrative cost per screened eligible was substantial, and (3) that the majority (95 percent) of State administrative costs for both States consisted of labor and overhead.

Impact of EPSDT on Total Medicaid Expenditures

- The EPSDT program increased total Medicaid expenditures in all of the four study situations.
- The cost of program administration at the State level was very low in both states. It played a very minor role in affecting the overall impact of the EPSDT program on total Medicaid expenditures in comparison to local site costs.
- The cost of program operation and administration at the local level was extremely high. Local level costs significantly increased EPSDT program costs and subsequently total Medicaid expenditures.

- The EPSDT population had lower expenditures for medical services than the non-EPSDT population in State 2 but not in State 1.
- In State 1, the increase in total Medicaid expenditures was a result of incurring EPSDT costs for State and local level operations and higher medical services expenditures for the EPSDT population in comparison to the non-EPSDT population.
- In State 2, the increase in total Medicaid expenditures was a result of incurring very high local site costs which offset the impact EPSDT had in decreasing costs for medical services.
- Break-even analysis indicates that 1) increasing the size of the screened population, 2) reducing the level of state and local costs, or 3) emphasizing those elements in the EPSDT program that lead to a decrease in unnecessary or costly utilization of medical services will produce a cost-effective EPSDT Program in State 2. A cost-effective EPSDT Program cannot be created in State 1, however, without first decreasing the utilization and subsequently expenditures for medical services by the screened population in comparison to the unscreened population.

SECTION III: INTERPRETATION OF FINDINGS

As indicated in Section II, considerable new information regarding EPSDT was gathered and analyzed in the three phases of the study just completed. While major findings and conclusions relating to each phase were presented in the relevant reports, briefly summarized in Section II, several additional conclusions emerged when all phases were complete and information was combined. Much information was also gathered in conversations with State and local EPSDT administrators and providers which bears on the program in general, but was not germane to any of the individual reports. This information, when combined with material reported earlier, broadens and enriches our findings about EPSDT program operation and administration. These broader findings, though, are not substitutes for information in the reports themselves. The following paragraphs discuss each finding.

Variations in nearly every aspect of EPSDT existed throughout the States and sites visited. The single consistent thread running through all locations was the basic function of screening. The same basic tests were performed everywhere and many test results were comparable (e.g., many dental problems existed, and these usually outweighed any other single problem referred for treatment).

A lack of substantial information existed to evaluate some of the major problem areas in EPSDT. For example, no real information exists or has been gathered to resolve questions of the efficacy of public versus private providers or the true relationship of costs to benefits in EPSDT.

Despite studies of EPSDT from the point of view of service providers, program administrators, welfare agencies, Medicaid agencies and others, no one seems to have investigated the EPSDT Program from the recipients' point of view. If the program

is truly to achieve some of its goals, such as encouraging recipients to utilize comprehensive care, the perceptions and needs of the recipient population must be investigated in a systematic manner.

State administrators as well as local providers have seen Federal enthusiasm and support for health programs decline after initial interest and implementation. They are hesitant to commit their scarce resources for program improvement to an effort which has not yet proven its viability over the long term. In essence, the breadth and depth of State and local commitment to EPSDT mirrors their perceptions of the degree of Federal commitment to health programs in general.

It was obvious that Federal regulations and guidelines, except the overall requirement to have a program in place and a 10 percent penalty for noncompliance, were generally unknown or unused by State and local program officials. No one mentioned them in our conversations without prompting, and Federally published materials such as A Guideline to Screening were not in evidence at local sites. From these observations, it was not obvious that further changes in regulations or guidelines would be effective in generating any but the grossest of changes in EPSDT. More subtle changes would seem to be dependent on an expanded base of information on costs and benefits in EPSDT, and on extended site-by-site technical assistance based on cost-benefit analysis.

Each program studied during the project has continued to evolve and improve over the past 12 months. Despite the common feeling that EPSDT is still in an extended startup phase, improvement seems to have been steady if not rapid.

Despite the proximity of administrators and providers to the EPSDT program at all levels, only a very superficial understanding about the program exists. This deficiency is partially due to a shortage of substantive literature concerning EPSDT. Neither analytical nor descriptive work is available which considers EPSDT

organization, component activities, or operating goals. Specific managerial expertise is required in such areas as operations management, financial planning and management, and marketing, but meaningful EPSDT literature is absent in these areas. Despite existence of some evaluative literature, no data are available that are particularly useful for further program evaluation. If such data are being collected, they are not reported, or they are reported in a manner that does not lend them to use as evaluation tools.

EPSDT is too frequently viewed in isolation from other factors that may directly affect the program. The Medicaid budgeting process, provider reimbursement schemes and levels, and Medicaid and welfare eligibility standards and processes are examples of factors that interact with EPSDT to produce characteristics of program operation (efficiency, cost, effectiveness, etc.). Interactions of various agencies and programs such as those occurring between health departments, school systems, and social service agencies also help to shape the EPSDT program, determine the population it serves, and the resources it requires. In summary, EPSDT must be interpreted within the broad framework of the health care system.

An adequate marketing effort was not seen in regard to EPSDT. Without significant attempts to "sell" EPSDT to recipients and providers, at least in the initial start-up period, the program will have difficulty in generating sufficient volume to operate cost effectively.

The traditional, non-economic orientation of public health departments and public health programs has extended to EPSDT. This orientation has become a barrier to the development of an economically viable program. For example, the philosophy of employing indigenous workers to alleviate local unemployment problems can come into direct conflict with the effort to improve health services delivery if both are attempted simultaneously.

Another example of a non-economic orientation is the overutilization of highly skilled labor, such as physicians, when less skilled staff can perform similar duties without a loss in quality. This practice can easily lead to extremely high costs per screened eligible. Inefficient practices such as these lessen the ability of EPSDT to survive in the event that Federal support is withdrawn at some future date and the full burden of EPSDT costs must be borne by State and local governments.

Finally, a misunderstanding exists in some States and local areas as to the intent of the screening process and program. Screening was not intended to replace the diagnostic functions of the private physician or of other comprehensive primary health care sources or to become a source of care and treatment. Screening is actually a gross mechanism for spotting easily identifiable symptoms or actual illnesses. As such, it performs a triage function to facilitate subsequent diagnosis and treatment. Without the correct interpretation of the philosophy and role of screening, the existing gulf between screening and treatment providers will continue to exist mirrored in the low level of referral completions.

SECTION IV: AREAS FOR FUTURE RESEARCH

Applied Management Sciences' staff has collected, compiled and presented information and data concerning EPSDT that have not been examined previously in a comprehensive and systematic fashion. Because of this presentation, the Assessment of EPSDT Practices and Costs is a benchmark study. However, several issues emerged during the study that require more extensive theoretical and analytical investigation than we were able to devote to them within this study.

The foremost issue requiring further study relates to the evolution and maturation of EPSDT programs in the States studied. We indicated in Section III that each program was seen to improve over the twelve months of this study, and the concept of program evolution was expressed by officials in every State visited. These findings suggest replication of the cost impact phase of our assessment at a later date in the two States we studied. For example, after an additional year has passed, we should reassess the utilization and expenditures impact of EPSDT in a multiple time series design. Our major hypothesis was that utilization and costs decrease as the program develops. This hypothesis could then be tested over at least two or three points in time.

In addition to providing data relating to stages in the development of EPSDT programs, cost reassessment would permit further estimation of cost-volume relationships, because screening volume changes over time. Knowledge of such relationships is valuable for program planning and budgeting at local, State, and federal levels. The appropriate methodology for a reassessment study would be replication of the approach used in our initial assessment. This approach would assure consistency of data, and facilitate comparison of costs over time and between sites.

A second area requiring further research relates to the problem of generalizability of cost data gathered in two States and four local sites. The problem suggests a study which would focus on the same issues as the one just completed, but utilizing a larger sample of states and sites, randomly selected.

In addition to a repetitive study using a more sophisticated evaluation design than presently used, another area for study and development is a standardized cost assessment methodology. Budgeting, bookkeeping and accounting are seldom performed on a program-specific basis at the State or local level. Therefore, portions of existing cost categories must be allocated to EPSDT. Current accounting categories differ from place to place, both in definition and in interpretation, further complicating cost allocation to EPSDT. To promote comparability, procedures could be developed that are compatible with the wide range of procedures now in use among State and local programs.

In summary, a study similar to the Report on the Cost Impact of the EPSDT Program just completed, but utilizing a larger, more representative sample, a standardized cost assessment methodology, and a multiple time series design would produce results that are both representative and generalizable to a larger population.

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